FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044073

Facility Name: HERITAGE MANOR-MOUNT ZION

Address: 1225 WOODLAND DRIVE (Number) MT. ZION (City) 61701 (Zip Code)

County: MACON

Telephone Number: (217) 864-2356 **Fax #** ( )

IDPA ID Number: 370909086024

Date of Initial License for Current Owners: 10/01/98

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: **Telephone Number:** ( )

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) CRAIG L. ATER
(Title) SENIOR V.P. FINANCE

Paid Preparer

(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	73	Skilled (SNF)	73	26,718	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	73	TOTALS	73	26,718	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,339	3,734	1,379	20,452	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	15,339	3,734	1,379	20,452	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.55%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [XX]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [XX]

I. On what date did you start providing long term care at this location?
Date started 1998

J. Was the facility purchased or leased after January 1, 1978?
YES [xx] Date 1998 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [XX] NO [ ] If YES, enter number of beds certified 6 and days of care provided 1379

Medicare Intermediary MUTUAL OF OHMAHA

IV. ACCOUNTING BASIS

ACCRUAL [XX] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [XX] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

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	G/L	RECAP CENSUS	DIFF
PP	3864	3864	0
IPA	15339	15339	0
medicare	1379	1379	0
	20582	20582	
IPA BEDHOLDS	0		
PP BEDHOLDS	130	0	
PP CONVERS	0		

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	110,471	7,843		118,314		118,314	1,773	120,087			1
2	Food Purchase		90,096		90,096		90,096	(452)	89,644			2
3	Housekeeping	45,971	8,492		54,463		54,463	0	54,463			3
4	Laundry	33,800	7,283		41,083		41,083	0	41,083			4
5	Heat and Other Utilities			73,443	73,443		73,443	618	74,061			5
6	Maintenance	15,227	26,684	14,440	56,351		56,351	6,275	62,626			6
7	Other (specify):*							0				7
8	TOTAL General Services	205,469	140,398	87,883	433,750		433,750	8,214	441,964			8
	B. Health Care and Programs											
9	Medical Director			16,000	16,000		16,000	0	16,000			9
10	Nursing and Medical Records	651,004	57,361	3,163	711,528		711,528	0	711,528			10
10a	Therapy		67,723	92,474	160,197	(216,879)	(56,682)	142,731	86,049			10a
11	Activities	28,664	942	112	29,718		29,718	0	29,718			11
12	Social Services	18,575	0	413	18,988		18,988	0	18,988			12
13	Nurse Aide Training	0	0					1,547	1,547			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	698,243	126,026	112,162	936,431	(216,879)	719,552	144,278	863,830			16
	C. General Administration											
17	Administrative	52,920			52,920		52,920	23,885	76,805			17
18	Directors Fees							1,812	1,812			18
19	Professional Services			156,699	156,699		156,699	(151,218)	5,481			19
20	Dues, Fees, Subscriptions & Promotions			54,717	54,717	(40,078)	14,639	(1,573)	13,066			20
21	Clerical & General Office Expenses	75,595	7,687	14,117	97,399		97,399	88,348	185,747			21
22	Employee Benefits & Payroll Taxes			160,506	160,506		160,506	13,933	174,439			22
23	Inservice Training & Education			370	370		370	660	1,030			23
24	Travel and Seminar			6,619	6,619		6,619	(4,620)	1,999			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			6,534	6,534		6,534	851	7,385			26
27	Other (specify):*			44,501	44,501		44,501	(44,486)	15			27
28	TOTAL General Administration	128,515	7,687	444,063	580,265	(40,078)	540,187	(72,408)	467,779			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,032,227	274,111	644,108	1,950,446	(256,957)	1,693,489	80,084	1,773,573			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			61,181	61,181		61,181	4,165	65,346			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			117,789	117,789		117,789	(562)	117,227			32
33	Real Estate Taxes			58,944	58,944		58,944	0	58,944			33
34	Rent-Facility & Grounds			0				5,081	5,081			34
35	Rent-Equipment & Vehicles			5,087	5,087		5,087	9,142	14,229			35
36	Other (specify):*							0				36
37	TOTAL Ownership			243,001	243,001		243,001	17,826	260,827			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					216,879	216,879	0	216,879			39
40	Barber and Beauty Shops	0	0	0				0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee					40,078	40,078	0	40,078			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers					256,957	256,957		256,957			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,032,227	274,111	887,109	2,193,447	0	2,193,447	97,910	2,291,357			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,509)	35		5
6	Rented Facility Space	0	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	0	30		9
10	Interest and Other Investment Income	(48)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(452)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(563)	20		17
18	Fines and Penalties				18
19	Entertainment	(8,777)	24		19
20	Contributions	0	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(2,361)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(44,486)	27		24
25	Fund Raising, Advertising and Promotional	(3,312)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	0	23		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (61,508)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	159,418		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 159,418		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 97,910		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Print Previe

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name **HERITAGE MANOR-MOUNT ZION**

ID# **0044073**

Report Period Beginning: **01/01/00**

Ending: **12/31/00**

Print Other Adjustment

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(452)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	0	0	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	(1,509)	35	**Line 5**	0
6	**Rented Facility Space**	0	34	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0		**Line 7**	0
8	**Laundry for Non-Patients**	0		**Line 8**	(452)
9	**Non-Straightline Depreciation**	0	30	**Line 9**	0
10	**Interest and Other Investment Income**	(48)	32	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	0		**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0		**Line 11**	0
13	**Sales Tax**	(452)	2	**Line 12**	0
14	**Non-Care Related Interest**	0	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0		**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	24	**Line 15**	0
17	**Non-Care Related Fees**	(563)	20	**Line 16**	0
18	**Fines and Penalties**	0		**Line 17**	0
19	**Entertainment**	(8,777)	24	**Line 18**	0
20	**Contributions**	0	27	**Line 19**	(2,361)
21	**Owner or Key-Man Insurance**	0		**Line 20**	(3,875)
22	**Special Legal Fees & Legal Retainers**	(2,361)	19	**Line 21**	0
23	**Malpractice Insurance for Individuals**	0		**Line 22**	0
24	**Bad Debt**	(44,486)	27	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(3,312)	20	**Line 24**	(8,777)
26	**Income & IL Personal Property ReplacementTaxes**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	0	0	**Line 27**	(44,486)
29	**Non-Paid Workers**	0	0	**Line 28**	(59,499)
30	**Donated Goods**	0	0	**Line 29**	(59,951)
31	**Amortization Expense**	0	0	**Line 30**	0
32		0		**Line 31**	0
33				**Line 32**	(48)
34				**Line 33**	0
35				**Line 34**	0
36				**Line 35**	(1,509)
37				**Line 36**	0
38				**Line 37**	(1,557)
39				**Line 38**	0
40				**Line 39**	0
41				**Line 40**	0
42				**Line 41**	0
43				**Line 42**	0
44				**Line 43**	0
45				**Line 44**	0
46				**Line 45**	(61,508)
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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	1,773	0	0	0	0	0	0	0	0	1,773	1
2	Food Purchase	(452)	0		0	0	0	0	0	0	0	0	(452)	2
3	Housekeeping	0	0		0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0		0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	618	0	0	0	0	0	0	0	0	618	5
6	Maintenance	0	0	6,275	0	0	0	0	0	0	0	0	6,275	6
7	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(452)	0	8,666	0	0	0	0	0	0	0	0	8,214	8
	B. Health Care and Programs													
9	Medical Director	0	0		0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0		0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	(4,476)		0	147,207	0	0	0	0	0	0	142,731	10a
11	Activities	0	0		0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0		0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,547	0	0	0	0	0	0	0	0	1,547	13
14	Program Transportation	0	0		0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0		0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(4,476)	1,547	0	147,207	0	0	0	0	0	0	144,278	16
	C. General Administration													
17	Administrative	0	0	23,885	0	0	0	0	0	0	0	0	23,885	17
18	Directors Fees	0	0	1,812	0	0	0	0	0	0	0	0	1,812	18
19	Professional Services	(2,361)	0	5,481	0	(154,338)	0	0	0	0	0	0	(151,218)	19
20	Fees, Subscriptions & Promotions	(3,875)	0	2,302	0	0	0	0	0	0	0	0	(1,573)	20
21	Clerical & General Office Expenses	0	0	88,348	0	0	0	0	0	0	0	0	88,348	21
22	Employee Benefits & Payroll Taxes	0	0	13,933	0	0	0	0	0	0	0	0	13,933	22
23	Inservice Training & Education	0	0	660	0	0	0	0	0	0	0	0	660	23
24	Travel and Seminar	(8,777)	0	4,157	0	0	0	0	0	0	0	0	(4,620)	24
25	Other Admin. Staff Transportation	0	0		0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	851	0	0	0	0	0	0	0	0	851	26
27	Other (specify):*	(44,486)	0	0	0	0	0	0	0	0	0	0	(44,486)	27
28	**TOTAL General Administration**	(59,499)	0	141,429	0	(154,338)	0	0	0	0	0	0	(72,408)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(59,951)	(4,476)	151,642	0	(7,131)	0	0	0	0	0	0	80,084	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense / D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	4,165	0	0	0	0	0	0	0	4,165	30
31	Amortization of Pre-Op. & Org.	0	0	0		0	0	0	0	0	0	0	0	31
32	Interest	(48)	0	0	(514)	0	0	0	0	0	0	0	(562)	32
33	Real Estate Taxes	0	0	0		0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	5,081	0	0	0	0	0	0	0	5,081	34
35	Rent-Equipment & Vehicles	(1,509)	0	0	10,651	0	0	0	0	0	0	0	9,142	35
36	Other (specify):*	0	0	0		0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,557)	0	0	19,383	0	0	0	0	0	0	0	17,826	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(61,508)	(4,476)	151,642	19,383	(7,131)	0	0	0	0	0	0	97,910	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-MOUNT ZIO# 0040872 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference; Adjustments for Related Organization Costs (7 minus 4)	
1	V		$			$	$	1
2	V	10c Adjustment for Related Organization	90,326	GreenTree Therapy	100.00%	85,850	(4,476)	2
3	V							3
4	V							4
5	V							5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		$ 90,326			$ 85,850	$ (4,476)	14

Sum_6 -4476

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6E, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6E, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6E, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 1,773	$ 1,773	15	1773
16	V	2	Food Purchase				0		16	
17	V	3	Housekeeping				0		17	
18	V	4	Laundry				0		18	
19	V	5	Heat & Other Utilities				618	618	19	618
20	V	6	Maintenance				6,275	6,275	20	6275
21	V	7	Other				0		21	
22	V	9	Medical Director				0		22	
23	V	10	Nursing & Medical Records				0		23	
24	V	11	Activities				0		24	
25	V	12	Social Service				0		25	
26	V	13	Nurse Aide Training				1,547	1,547	26	1547
27	V	14	Program Transportation				0		27	
28	V	15	Other				0		28	
29	V	17	Administrative				23,885	23,885	29	23885
30	V	18	Directors Fees				1,812	1,812	30	1812
31	V	19	Professional Services				5,481	5,481	31	5481
32	V	20	Fees, Subscription, Promotions				2,302	2,302	32	2302
33	V	21	Clerical & General Office Expenses				88,348	88,348	33	88348
34	V	22	Employee Benefits & Payroll Taxes				13,933	13,933	34	13933
35	V	23	Inservice Training & Education				660	660	35	660
36	V	24	Travel and Seminar				4,157	4,157	36	4157
37	V	25	Other Admin. Staff Transportation				0		37	
38	V	26	Insurance-Prop.Liab.Malpract				851	851	38	851
39	Total			$			$ 151,642	$ * 151,642	39	

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6B
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$ 0	$	15	
16	V	30	Depreciation				4,165	4,165	16	4165
17	V	31	Amortization of Pre-Op & Org				0		17	
18	V	32	Interest				(514)	(514)	18	-514
19	V	33	Real Estate Taxes				0		19	
20	V	34	Rent-Facility & Grounds				5,081	5,081	20	5081
21	V	35	Rent-Equipment & Vehicles				10,651	10,651	21	10651
22	V	36	Other				0		22	
23	V	38	Medically Nec Transportation				0		23	
24	V	39	Ancillary Service Centers				0		24	
25	V	40	Barber and Beauty Shops				0		25	
26	V	41	Coffee and Gift Shops				0		26	
27	V	42	Other				0		27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 19,383	$ * 19,383	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Print Page 6

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6C
15	V	19	Adjustment for Related Organization	$ 154,338	Heritage Enterprises, Inc.		$	$ (154,338)	15	-154338
16	V								16	
17	V	10a	Adjustment for Related Organization	67,524	Green Tree Pharmacy	100.00%	214,731	147,207	17	147207
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$ 221,862			$ 214,731	$ * (7,131)	39	

* Total must agree with the amount recorded on line 34 of Schedule VI.

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Print Page 6

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Chairman of Board	Management	0.26	18,319	10	0.20	Directors Fee	$ 911	line 18, col 7	1
2	Tom Jefferson	Asst Secretary/Treas	Management	0.10	18,320	10	0.20	Directors Fees	910	line 18, col 7	2
3	Craig Hart	Secretary/Treasurer	Management	0.20	18,320	10	0.20	Directors Fees	910	line 18, col 7	3
4	Bill Froelich	Chairman of Board	Management	0.26	130,991	10	0.20	Salary	6,509	line 17, col 7	4
5	Tom Jefferson	Asst Secretary/Treas	Management	0.10	130,992	10	0.20	Salary	6,508	line 17, col 7	5
6	Craig Hart	Secretary/Treasurer	Management	0.20	108,477	10	0.20	Salary	5,390	line 17, col 7	6
7	Joe Warner	President	Management	0.03	102,377	48	0.95	Salary	5,086	line 17, col 7	7
8	Bob Dickson	Executive Vice Presid	Management	0.01	66,703	50	1.00	Salary	3,314	line 17, col 7	8
9	Cheryl Lowney	Executive Vice Presid	Management	0.00	54,949	50	1.00	Salary	2,730	line 17, col 7	9
10	Steve Wannemacher	Executive Vice Presid	Management	0.00	54,672	50	1.00	Salary	2,716	line 17, col 7	10
11	Connie Hoselton	Sr Vice President	Management	0.00	33,750	40	1.00	Salary	1,677	line 17, col 7	11
12	Craig Ater	Sr Vice President	Management	0.00	41,492	50	1.00	Salary	2,061	line 17, col 7	12
13								TOTAL	$ 38,722		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington, Il 61701
Phone Number: (309) 823-7135
Fax Number: (309) 829-5477

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	BEDS	2,324	23	$ 56,457	$ 56,457	73	$ 1,773	1
2	2	Food Purchase	BEDS	2,324	23	6	0	73	0	2
3	3	Housekeeping	BEDS	2,324	23	0	0	73	0	3
4	4	Laundry	BEDS	2,324	23	0	0	73	0	4
5	5	Heat & Other Utilities	BEDS	2,324	23	19,665	0	73	618	5
6	6	Maintenance	BEDS	2,324	23	199,772	50,885	73	6,275	6
7	7	Other	BEDS	2,324	23	0	0	73	0	7
8	9	Medical Director	BEDS	2,324	23	0	0	73	0	8
9	10	Nursing & Medical Records	BEDS	2,324	23	0	0	73	0	9
10	11	Activities	BEDS	2,324	23	0	0	73	0	10
11	12	Social Service	BEDS	2,324	23	0	0	73	0	11
12	13	Nurse Aide Training	BEDS	2,324	23	49,237	43,081	73	1,547	12
13	14	Program Transportation	BEDS	2,324	23	0	0	73	0	13
14	15	Other	BEDS	2,324	23	0	0	73	0	14
15	17	Administrative	BEDS	2,324	23	760,393	760,393	73	23,885	15
16	18	Directors Fees	BEDS	2,324	23	57,693	0	73	1,812	16
17	19	Professional Services	BEDS	2,324	23	174,483	0	73	5,481	17
18	20	Fees, Subscription, Promotions	BEDS	2,324	23	73,288	0	73	2,302	18
19	21	Clerical & General Office Expense	BEDS	2,324	23	2,812,617	2,533,181	73	88,348	19
20	22	Employee Benefits & Payroll Taxe	BEDS	2,324	23	443,562	0	73	13,933	20
21	23	Inservice Training & Education	BEDS	2,324	23	21,017	0	73	660	21
22	24	Travel and Seminar	BEDS	2,324	23	132,330	0	73	4,157	22
23	25	Other Admin. Staff Transportatio	BEDS	2,324	23	0	0	73	0	23
24	26	Insurance-Prop.Liab.Malpract	BEDS	2,324	23	27,096	0	73	851	24
25	TOTALS					$ 4,827,616	$ 3,443,997		$ 151,642	25

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Print Page 8

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,324	23	$ 0	$ 0	71	$ 0	1
2	30	Depreciation	BEDS	2,324	23	136,322	0	71	4,165	2
3	31	Amortization of Pre-Op & Org	BEDS	2,324	23	0	0	71	0	3
4	32	Interest	BEDS	2,324	23	(16,821)	0	71	(514)	4
5	33	Real Estate Taxes	BEDS	2,324	23	0	0	71	0	5
6	34	Rent-Facility & Grounds	BEDS	2,324	23	166,328	0	71	5,081	6
7	35	Rent-Equipment & Vehicles	BEDS	2,324	23	348,617	0	71	10,651	7
8	36	Other	BEDS	2,324	23	0	0	71	0	8
9	38	Medically Nec Transportation	BEDS	2,324	23	0	0	71	0	9
10	39	Ancillary Service Centers	BEDS	2,324	23	0	0	71	0	10
11	40	Barber and Beauty Shops	BEDS	2,324	23	0	0	71	0	11
12	41	Coffee and Gift Shops	BEDS	2,324	23	0	0	71	0	12
13	42	Other	BEDS	2,324	23	0	0	71	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 634,446	$		$ 19,383	25

Print Previe

Print Page 8

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Previe

Print Page 8

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Print Page 8

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	National City		XX	Mortage	$10,137.00	10/01/98	$ 3,460,000	$ 1,252,589	10/01/01	0.0825	$ 86,802	1
2	National City Loan Amortization		XX	Mortgage							1,351	2
3	Central Office Allocation		XX	Interest Income							(514)	3
4			xx								0	4
5												5
	Working Capital											
6												6
7	National City working Capital										29,636	7
8												8
9	TOTAL Facility Related				$10,137.00		$ 3,460,000	$ 1,252,589			$ 117,275	9
	B. Non-Facility Related*											
10	Interest Income										(48)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,460,000	$ 1,252,589			$ 117,227	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	58,142	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	57,115	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,027)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	59,971	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	58,944	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	50,411	8
	1996	53,400	9
	1997	58,759	10
	1998	57,580	11
	1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Brick/Wood Frame Number of Stories

C. Does the Operating Entity? [XX] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home		10/01/98	$ 50,000	1
2	Nursing Home				2
3	TOTALS			$ 50,000	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	73				$ 1,076,000	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Environmental Site Study			1998	1,662						9
10	Sign			1998	1,860						10
11	Air conditioning Unit			1999	5,732						11
12	Air Conditioner			1999	750						12
13	Professional Fees --Remodeling Project			1999	15,922						13
14											14
15	Facility Remodel -- Materials			2000	241,637						15
16	Professional Fees --Remodeling Project			2000	58,519						16
17	Kitchen A/C			2000	990						17
18	Fire Alarm			2000	1,997						18
19	Door Guard System			2000	3,444						19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	C/O Allocation							4,165	4,165		34
35	Book Depreciation					28,578		28,578		62,726	35
36	TOTAL (lines 4 thru 35)				$ 1408513	$ 28,578		$ 32,743	$ 4,165	$ 62,726	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 217,343	$ 32,603	$ 32,603	$		$ 71,127	37
38	Current Year Purchases	14,441						38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 231,784	$ 32,603	$ 32,603	$		$ 71,127	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 61,181	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 65,346	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 4,165	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 133,853	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 0			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$ 0
13.	/2002	$ 0
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 14,229 Description: Copier, Cell Phone and Central Office Allocation
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		0		
3	Classroom Wages (a)		0		
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		1,547		1,547
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 1,547	$	$ 1,547
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,547			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a/3	hrs	$		$ 32,244	$		$ 32,244	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			6,825			6,825	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			46,781	199		46,980	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescrpts				214,731		214,731	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab	39/3				2,148			2,148	13
14	TOTAL			$		$ 87,998	$ 214,930		$ 302,928	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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pt adj -5953
st adj 2935
Ot adj -1458

drugs 147207

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 556	$	1
2	Cash-Patient Deposits	499		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	331,955		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,236		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,128,861)		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (794,615)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	50,000		13
14	Buildings, at Historical Cost	1,408,514		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	231,784		16
17	Accumulated Depreciation (book methods)	(133,853)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	3,939		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,560,384	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 765,769	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 19,852	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	499		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	93,793		30
31	Accrued Taxes Payable (excluding real estate taxes)	8,827		31
32	Accrued Real Estate Taxes(Sch.IX-B)	59,971		32
33	Accrued Interest Payable	7,259		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		0		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 190,201	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,252,589		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,252,589	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,442,790	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (677,021)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 765,769	$	48

***(See instructions.)**

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (397,483)	1
2	Restatements (describe):		2
3	audit Adjustment	(15,361)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (412,844)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(264,177)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (264,177)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (677,021)	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,045,210	1
2	Discounts and Allowances for all Levels	(391,129)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,654,081	3
	B. Ancillary Revenue		
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	143,256	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 143,256	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	0	11
12	Gift and Coffee Shop	756	12
13	Barber and Beauty Care	438	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	0	16
17	Sale of Drugs	131,023	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(332)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 131,885	23
	D. Non-Operating Revenue		
24	Contributions	0	24
25	Interest and Other Investment Income***	48	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	other	0	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,929,270	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 433,750	31
32	Health Care	936,431	32
33	General Administration	580,265	33
	B. Capital Expense		
34	Ownership	243,001	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37		0	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,193,447	40
41	**Income before Income Taxes (line 30 minus line 40)****	(264,177)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (264,177)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,961	2,174	$ 38,467	$ 17.69	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	5,485	5,606	100,201	17.87	3
4	Licensed Practical Nurses	11,461	12,285	138,923	11.31	4
5	Nurse Aides & Orderlies	39,724	42,082	336,929	8.01	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,278	3,545	36,484	10.29	8
9	Activity Director					9
10	Activity Assistants	3,678	4,022	28,664	7.13	10
11	Social Service Workers	1,936	2,123	18,575	8.75	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,329	15,974	110,471	6.92	15
16	Dishwashers					16
17	Maintenance Workers	1,437	1,627	15,227	9.36	17
18	Housekeepers	6,337	6,650	45,971	6.91	18
19	Laundry	4,559	4,805	33,800	7.03	19
20	Administrator	2,080	2,080	52,920	25.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,468	6,973	75,595	10.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	103,733	109,946	$ 1,032,227 *	$ 9.39	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director		16,000		36
37	Medical Records Consultant		1,280		37
38	Nurse Consultant				38
39	Pharmacist Consultant		850		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		413		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 18,543		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Lisa Wernsing	Administrator	0.00%	$ 52,920
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 52,920

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Management Fees	$ 154,338
All Legal is adjusted to zero	Legal	2,361
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 156,699

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,849
Unemployment Compensation Insurance	10,714
FICA Taxes	78,965
Employee Health Insurance	35,651
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	11,327
Employee Benefits - central office	13,933
TOTAL (agree to Schedule V, line 22, col.8)	$ 174,439

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	6,332
Health Care Worker Background Check	
(Indicate # of checks performed)	217
Central Office Allocation	2,302
Promotional Advertising	915
Public Relations	2,397
Dues and Subscriptions	4,243
License and Fees	335
Non Allowable Fee	0
Less: Public Relations Expense	(2,397)
Non-allowable advertising	(563)
Yellow page advertising	(915)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,066

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	2,023
	104
Seminar Expense	4,492
Non Allowable	(8,777)
Central Office Allocation	4,157
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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Facility Name & ID Number HERITAGE MANOR-MOUNT ZION # 0044073 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **yes** If YES, have these costs
been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **5,000** Line

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **xx** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **40,078**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **no** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **yes** Indicate the amount. $ **224**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned for providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **no** If no, please explain. **Not complete as of the filing date.**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Account Number		Description	G/L Balance	Cost Rpt Grouping	Sch 5 pg 3/4 Line #	Sch 5 pg 3/4 Col #	Sch 6 pg 5 Line #	Adjustment Amount								
1009		PETTY CASH	556							1009	1010 CASH IN BA	556				
1010		CASH IN BANK								1100	1100 ACCTS REC	95,554				
1040		CASH IN BANK-PAYROLL								1101	1101 ALLOWAN	(50,000)				
1100		ACCOUNTS RECEIVABLE	331955							1105	1110 ACCTS REC	105,035				
1110		MEDICARE RECEIVABLES								1110	1125 ACCTS REC	154,806				
1125		IPA INCOME RECEIVABLE								1125	1135 ACCTS REC	26,560				
1130		MEDICARE COST REPORT								1130	1140 UNAPPLIEI	0				
1135		ACCOUNTS RECEIVABLE-IC								1135	1145 A/R SUSPEI	0				
1140		UNAPPLIED CASH RECEIPTS								1140						
1145		A/R SUSPENSE-REFUNDS								1145						
1190		ACCRUED INTEREST REC								1200	1200 PREPAID IN	0				
1200		PREPAID INSURANCE	1236							1220	1220 OTHER PRI	1,236				
1220		OTHER PREPAID EXPENSES								1300						
1300		FOOD INVENTORY								1310						
1310		SUPPLIES INVENTORY								1320						
1409		LAND	50000							1409	1409 LAND	50,000				
1450		FURNITURE & EQUIPMENT	231784							1450	1450 FURNITUR	231,784				
1460		ACCUM DEPR-FURN & EQUIP	-71127							1460	1460 ACCUM DE	(71,127)				
1475		BUILDING & IMPROVEMENTS	1408514							1475	1475 BUILDING	1,408,514				
1490		ACCUM DEPR-BUILDING	-62726							1490	1490 ACCUM DE	(62,726)				
1530		RESIDENT FUNDS	499							1530	1530 RESIDENT	499				
1550		LOAN FEES	3939							1550	1550 LOAN FEES	3,939				
1560		REAL ESTATE TAX ESCROW								1551	1551 LOAN FEES	0				
1575		REIMBURSABLE PURCHASES								1575						
1850		INTRACOMPANY	-1128861							1850	1850 INTERCOM	(1,128,861)				
2010		ACCOUNTS PAYABLE	-19852							2010	2010 ACCOUNTS	(19,852)				
2095		BONUSES PAYABLE								2095	2095 BONUSES I	0				
2100		ACCRUED PAYROLL	-49199							2100	2100 ACCRUED	0				
2110		ACCRUED VACATION PAY	-44594							2100	2100 PR CLEARI	(2,508)				
2120		UC TAXES PAYABLE								2100	2100 PR CLEARI	(42,638)				
2125		FICA TAX PAYABLE	-8827	-8827						2100	2100 PR CLEARI	(4,053)				
2130		FIT PAYABLE								2110	2110 ACCRUED	(44,594)				
2140		STATE W/H PAYABLE		0						2120	2120 U.C. TAXES	(1,191)				
2145		EARNED INCOME CREDIT								2125	2125 FICA TAXE	0				
2150		UC FED CREDIT REDUCTION								2130	2130 FEDERAL V	0				
2230		PAYROLL SAVINGS								2140	2140 STATE W/H	0				
2235		IRA W/HOLDINGS								2145	2145 EARNED IN	0				
2240		UNITED WAY								2152	2152 WORKERS	(7,500)				
2245		GROUP INSURANCE PAYABLE								2225	2225 EMPLOYEE	0				
2246		GROUP INSURANCE PAYABLE-CAFETERIA								2230	2241 P/R W/H IN	0				
2260		WAGE GARNISHMENTS								2235	2246 GROUP INS	0				
2280		MISC PAYROLL DEDUCTIONS								2240	2250 401K-W/H	0				
2300		ACCRUED INTEREST PAYABLE	-7259							2246						
2310		SALES TAX PAYABLE								2250	2280 MISC PAYR	(100)				
2320		IPA PAYMENTS PAYABLE								2260	2260 WAGE GAR	(36)				
2350		REAL ESTATE TAX PAYABLE	-59971							2300	2300 ACCRUED	(7,259)				
2385		ACTIVITY FUND	0							2320	2320 IPA PAYME	0				
2390		SECURITY DEPOSITS								2350	2350 REAL ESTA	(59,971)				
2391		VOLUNTEER FUND								2385						
2393		HEART FUND/BAZAAR								2391						
2395		DEFERRED INC EMP & MEM								2393						
2400		CURRENT PORTION LT DEBT								2395						
2460		INCOME TAXES PAYABLE								2400						
2512		DUE TO RESIDENTS	-499							2512	2512 DUE TO RE	(499)				
2600		MORTGAGE PAYABLE	-1252589							2600	2600 LASALLE E	(1,252,589)				
2650		EQUIPMENT LOAN PAYABLE								2600	2600 LOAN ADD	0				
2695		CURRENT PORTION LT DEBT								2625	2625 LASALLE C	0				
2696		DEFERRED INCOME TAXES								2625						
2710		COMMON STOCK								2695						
2720		RETAINED EARNINGS	412844							2720	2720 RETAINED	412,844				
2970		PROFIT/LOSS FOR PERIOD	264177								2720 RETAINED	264,177				
3007.1		PATIENT DAYS-PRIVATE	3864										3007	3007 PATIENT D	3,864	
3007.2		PATIENT DAYS-IPA	15339									0	3007	3007 PATIENT D	15,339	
3007.3		PATIENT DAYS-MEDICARE	1379										3007	3007 PATIENT D	1,379	
3007.4		PATIENT DAYS-CONVERSION											3007	3007 PATIENT DAYS-CONVERSION		
3007.5		PATIENT DAYS-LICENSED											3007	3007 PATIENT DAYS-LICENSED		
3007.6		PATIENT DAYS-TOTAL											3007	3007 PATIENT DAYS-TOTAL		
3010		1 BASIC CHARGE-PRIVATE & VA	-345054		0	0	0	0					3007	3007 PATIENT DAYS-CONTRA ACCOUNT		
3015		1 PRIVATE ASSESSMENT TAX INCOME			0	0	0	0					3010	3010 BASIC CHA	(345,054)	
3020		1 BASIC CHARGE-IPA	-1146740		0	0	0	0					3015			
3030		1 BASIC CHARGE-MEDICARE	-337893		0	0	0	0					3020	3020 BASIC CHA	(1,146,740)	
3035		4 DAY CARE/HOME CARE			0	0	0	0					3030	3030 BASIC CHA	(337,893)	
3040		1 LIGHT NURSING CARE	-11833		0	0	0	0					3035			
3050		1 MEDIUM NURSING CARE			0	0	0	0					3040	3040 LIGHT NUR	(154)	
3060		1 HEAVY NURSING CARE			0	0	0	0					3050	3050 MEDIUM N	(1,271)	
3061		1 SKILLED NURSING CARE											3060	3060 HEAVY NU	(972)	
3080		1 NURSING SUPPLIES-PRIVATE	-203690		0	0	0	0					3061	3061 SKILLED N	(9,436)	
3081		1 NURSING SUPPLIES-IPA			0	0	0	0					3080	3080 NURSING S	(21,058)	
3082		1 NURSING SUPPLIES MED PT A			0	0	0	0					3081	3081 NURSING S	(151,237)	
3083		1 NURSING SUPPLIES MED PT B											3082	3082 NURSING S	(19,906)	
3100		17 DRUGS	-131023		0	0	0	0					3083	3083 NURSING S	(11,489)	
3101		17 DRUGS-OTHER											3100	3100 DRUGS-ME	(66,696)	
3110		6 PT-PRIVATE	-143256		0	0	0	0					3101	3101 DRUGS-OT	(64,327)	
3111		6 PT-IPA			0	0	0	0					3110	3110 PHYSICAL	1,102	
3112		6 PT-MEDICARE PART A			0	0	0	0					3111	3111 PHYSICAL	0	
3113		6 PT-MEDICARE PART B			0	0	0	0					3112	3112 PHYSICAL	(74,280)	
3130		1 PUBLIC AID ASSESSMENT INC											3113	3113 PHYSICAL	(11,490)	
3140		19 LABORATORY INCOME			0	0	0	0					3130	3140 LABORATO	(340)	
3150		6 SPEECH/OT-PRIVATE			0	0	0	0					3140			
3151		6 SPEECH/OT-IPA			0	0	0	0					3150			
3152		6 SPEECH/OT-MED PART A			0	0	0	0					3151	3151 ST/OT THE	(280)	
3153		6 SPEECH/OT MED PART B											3152	3152 ST/OT THE	(51,000)	
3410		2 IPA DISCOUNTS	391129		0	0	0	0					3153	3153 ST/OT THE	(6,968)	
3411		2 MEDICAID PART B DISCOUNT			0	0	0	0					3160	3160 X-RAY SER	0	
3420		2 MEDICARE DISCOUNTS			0	0	0	0					3410	3410 IPA/OTHER	166,127	
3440		36 ASSESSMENT TAX EXPENSE			42	3	0	0					3411	3411 MEDICARE	3,903	
3520		16 RENT INCOME	0		6	0	6	0					3415	3420 MEDICARE	212,473	
3530		13 BEAUTY SHOP	-438		0	0	0	0					3420	3450 MEDICARE	8,626	
3560		12 ACTIVITY FUND INCOME	0		0	0	0	0					3440			
3570		12 VENDING INCOME/EXPENSE	-756		0	0	0	0					3450			
3580		12 MANAGEMENT FEES			0	0	0	0					3460			
3590		1 EQUIPMENT RENTAL	0		0	0	0	0					3500			
3595		21 RESIDENT TRANSPORTATION	0		0	0	0	0					3520			
3600		21 MISC INCOME	332		0	0	0	0					3530	3530 BEAUTY SI	(438)	
4110		GENERAL & ADMINIST WAGES	70864	75595	21	1	17	0					3560			
4111		ADMINISTRATOR WAGES	52920	52920	17	1	0	0					3570	3570 VENDING I	(756)	
4115		VACATION & SICK - G&A	4731		21	1	0	0					3580			
4120	4475	EMPLOYEE BENEFITS	10357	160506	22	3	0	0					3590	3590 EQUIPMEN	0	
4125		EMPLOYEE HEPETITIS VACCINE	0		22	3	0	0					3595			
4130		EMPLOYEE SCHOLORSHIP WAGE	517		21	1	0	0					3600	3600 MISC INCO	332	-1929222
4135		EMPLOYEE SCHOLORSHIP COST	453		23	3	0	0					4110	4110 G&A WAGI	67,960	
4220		DIRECTORS FEES			18	3	0	0					4111	4111 ADMINISTI	52,920	
4250	4255	OFFICE SUPPLIES	7687	7687	21	2	0	0					4115	4115 G&A PTO &	4,731	
4260		TELEPHONE	14117	14117	21	3	0	0					4120	4120 EMPLOYEE	5,874	
4275		TRAINING & EMPLOYEE DEVL	370	370	23	3	16	0 **					4125	4125 EMPLOYEE	0	
4280		GENERAL TRAVEL	2023	6619	24	3	16	0					4130	4130 EMPLOYEE	517	
4281		MEAL EXPENSE FOR TRAVEL	104		24	3	19	0					4135	4135 EMPLOYEE	453	
4285		EDUCATION & SEMINAR	4492		24	3	19	-8777 ***					4245	4245 TEMPS/CO	2,904	
4290		HELP WANTED ADVERTISING	6332	54717	20	3	0	0	-40078				4250	4250 OFFICE SU	4,361	
4291		PROMOTIONAL ADVERTISING	915		20	3	25	-915					4255	4255 POSTAGE	1,483	
4292		PUBLIC RELATIONS	2397		20	3	25	-2397					4260	4260 TELEPHON	14,117	
4300		LICENSES & FEES	40613		20	3	17	0					4275	4275 TRAINING	370	
4310		DUES & SUBSCRIPTIONS	4243		20	3	17	-563					4276	4276 INJURY PR	552	
4320		CONTRIBUTIONS	0		27	3	20	0					4280	4280 GENERAL	2,023	
4350		PROFESSIONAL FEES	2361	156699	19	3	22	-2361					4281	4281 MEAL EXP	104	
4355		MEDICAL DIRECTOR	16000	16000	9	3	0	0					4285	4285 EDUCATIO	4,352	
4360		UTILIZATION REVIEW	0		10	3	0	0					4289	4289 MEETINGS	140	
4361		OTHER PHYSICIAN FEES	0		39	3	0	0					4290	4290 HELP WAN	6,332	
4362		MEDICAL RECORDS CONSULT	1280		10	3	0	0					4291	4291 PROMOTIO	915	
4363		PHARMACIST FEES	850		10	3	0	0					4292	4292 PUBLIC RE	2,397	
4364		SOC SERV/ACT CONSULT	413	413	12	3	0	0					4300	4300 LICENSE &	40,613	
4370		TV RENTAL	1509		35	3	5	-1509					4310	4310 DUES & SU	4,243	
4380		INCOME TAXES		44501	27	3	26	0					4320	4320 CONTRIBU	0	
4383		BACKGROUND CHECKS	217		20	3	26	0					4350	4350 PROFESSIO	2,361	
4400		PAYROLL TAXES	84440		22	3	0	0					4355	4355 MEDICAL I	16,000	
4401		PAYROLL TAXES ADMINIST	5239		22	3	0	0					4360	4360 UTILIZATIO	0	
4410		GROUP INSURANCE	35651		22	3	0	0					4361	4361 OTHER PHY	0	
4420		LIABILITY INSURANCE	6534	6534	26	3	0	0					4362	4362 MEDICAL I	1,280	
4425		INSURANCE-OWNERS			22	3	21	0					4363	4363 PHARMACI	850	
4430		WORKMENS COMP INSURANCE	23849		22	3	0	0					4364	4364 SOCIAL SE	413	
4450		CENTRAL OFFICE FEES	154338		19	3	34	-154338					4370	4370 TV RENTAI	1,509	
4460		BAD DEBTS	44486		27	3	24	-44486					4383	4383 BACKGROU	217	
4470		LOST ITEMS-RESIDENTS	15		27	3	0						4390	4390 OTHER TA	0	
4490		MISCELLANEOUS			27	3	0	0					4400	4400 PAYROLL	84,440	
4510		REAL ESTATE TAXES	58944	58944	33	3	0	0					4401	4401 PAYROLL	5,239	
4600		LEASED EQUIPMENT	3578	5087	35	3	16	0					4410	4410 GROUP INS	35,651	
5110		MAINTENANCE SALARIES	14417	15227	6	1	0	0					4420	4420 LIABILITY	6,534	
5120		MAINTENANCE SICK & VAC	810		6	1	0	0					4430	4430 WORKMAN	22,198	
5130		ELECTRIC	54871	73443	5	3	0	0					4435	4435 W/C-FIRST	1,099	
5131		NATURAL GAS	0		5	3	0	0					4436	4436 DRUG TES	0	
5132		HEATING & DEISEL OIL			5	3	0	0					4440			
5133		WATER & SEWER	18572		5	3	0	0					4450	4450 CENTRAL	154,338	
5134		TRASH COLLECTION	2145	14440	6	3	0	0					4460	4460 BAD DEBT	42,895	
5140		PROPERTY PLANT REPLACEMNT	9007	26684	6	2	0	0					4461	4461 BAD DEBT	1,591	
5160		GENERAL REPAIR & MAINT	17677		6	2	0	0					4470	4470 LOST ITEM	15	
5165		MAINTENANCE CONTRACTS	12295		6	3	0	0					4475	4475 UNIFORM I	4,483	
5210		DIETARY WAGES	105719	110471	1	1	0	0					4486	4486 SERVICE C	2,898	
5220		DIETARY SICK & VAC	4752		1	1	0	0					4490	4490 MISC EXPE	(794)	
5240		SALES TAX			2	3	13	-452					4496	4496 MISC. M.I.S	1,843	602421
5248		FOOD PURCHASES	90320	90096	2	2	0	0					4510	4510 REAL ESTA	58,944	
5250		SUPPLIES-DISHWASHING	1924	7843	1	2	0	0					4600	4600 LEASED EQ	3,578	
5260		DIETARY REPLACEMENT	1312		1	2	0	0					5110	5110 MAINTENA	14,417	
5270		KITCHEN SUPPLIES-PAPER	4607		1	2	0	0					5120	5120 MAINTENA	810	
5295		MEAL CREDIT	-224		2	2	0	0					5130	5130 ELECTRIC	54,871	
5310		LAUNDRY WAGES	31528	33800	4	1	0	0					5131	5131 NATURAL	0	
5340		LAUNDRY SICK & VAC	2272		4	1	0	0					5133	5133 WATER & S	18,572	
5370		LAUNDRY REPLACEMENT	3337	7283	4	2	0	0					5134	5134 TRASH CO	2,145	
5380		LAUNDRY REIMBURSEMENT			4	3	0	0					5140	5140 PROP/PLAN	9,007	
5390		LAUNDRY SUPPLIES	3946		4	2	0	0					5160	5160 GENERAL I	17,677	
5410		HOUSEKEEPING WAGES	43051	45971	3	1	0	0					5165	5165 MAINTENA	9,397	
5440		HOUSEKEEPING SICK & VAC	2920		3	1	0	0					5166			
5480		HOUSEKEEPING SUPPLIES	1511	8492	3	2	0	0					5210	5210 DIETARY V	105,719	
5490		HOUSEKEEPING SUPPLIES-PPR	6981		3	2	0	0					5220	5220 DIETARY P	4,752	
6010		RN WAGES-MEDICARE		651004	10	1	0	0					5240			
6020		RN WAGES-NON MEDICARE	90334		10	1	0	0					5245			
6030		DON WAGES	38467		10	1	0	0					5248	5248 FOOD PUR	91,114	
6035		ADON	0		10	1	0	0					5250	5250 SUPPLIES I	1,924	
6040		RN SICK & VACATION	9867		10	1	0	0					5260	5260 REPLACEM	1,312	
6110		LPN WAGES-MEDICARE			10	1	0	0					5270	5270 KITCHEN S	4,607	
6120		LPN WAGES-NON MEDICARE	126285		10	1	0	0					5295	5295 MEAL INC	(224)	
6130		LPN WAGES OTHER			10	1	0	0					5310	5310 LAUNDRY	31,528	
6140		LPN SICK & VACATION	12638		10	1	0	0					5340	5340 LAUNDRY	2,272	
6210		AIDE WAGES-MEDICARE			10	1	0	0					5370	5370 REPLACEM	3,337	
6220		AIDE WAGES-NON MEDICARE	315821		10	1	0	0					5380	5380 OUTSIDE L	331	
6230		WARD CLERKS			10	1	0	0					5390	5390 SUPPLIES	3,615	
6240		AIDE VACATION & SICK	21108		10	1	0	0					5410	5410 HOUSEKEE	43,051	
6245		CONTRACT NURSES-RN	0		10	3	0	0					5440	5440 HOUSEKEE	2,920	
6246		CONTRACT NURSES-LPN	0		10	3	0	0					5480	5480 SUPPLIES-C	1,511	
6247		CONTRACT NURSES-AIDES	0		10	3	0	0					5490	5490 SUPPLIES-I	6,981	
6250		NURSE AIDE TRAINING WAGES	0	0	13	1	0	0					6010			
6255		NURSE AID TRAINING EXP	0	0	13	2	0	0					6020	6020 RN WAGES	90,334	
6260		NURSE AIDE TRAINING REIMB	0		0	0	0	0					6030	6030 DON WAGI	38,467	
6270		REHAB WAGES	36484		10	1	0	0					6035			
6275		REHAB SICK & VAC	0		10	1	0	0					6040	6040 RN PTO & I	9,867	
6280		NURSING DEPT EDUCATION			23	3	0	0					6110			
6290		NURSING SUPPLIES	51992	57361	10	2	0	0					6120	6120 LPN WAGE	126,285	
6295		NURSING SUPPLIES	4215		10	2	0	0					6130			
6390		REPLACEMENT-NURSING	1154		10	2	0	0					6140	6140 LPN PTO &	12,638	
6490		NURSING OTHER	1033	3163	10	3	0	0					6210			
7280		DRUG PURCHASES	33207	67723	39	2	0	147207 ***					6220	6220 AIDES WA	315,821	
7281		DRUG PURCHASES-OTHER	34317		39	2							6230			
7380		LABORATORY SERVICES	2148	92474	39	3	0	0					6240	6240 AIDES PTO	21,108	
7410		HOME HEALTH SALARY			39	1	0	0					6245			
7440		HOME HEALTH SICK & VAC			39	1	0	0					6246			
7450		HOME HEALTH EXPENSES			39	3	0	0					6247			
7510		ACTIVITES WAGES	27665	28664	11	1	0	0					6250	6250 NURSE AID	0	
7540		ACTIVITIES SICK & VAC	999		11	1	0	0					6255			
7590		ACTIVITIES SUPPLIES	942	942	11	2	0	0					6260			
7595		ACTIVITIES FEES	112	112	11	3	0	0					6270	6270 REHAB WA	36,484	
7610		PT WAGES			39	1	0	0					6275	6275 REHAB PT	0	
7611		PT SICK & VACATION			39	1	0	0					6280	6279 REHAB TH	0	
7620		PT FEES	52734		39	3	0	-5953 ***					6290	6290 NURSING S	51,992	
7660		PT SUPPLIES	199		39	2	0	0					6295	6295 NURSING S	4,215	
7710		SOCIAL SERVICE WAGES	16986	18575	12	1	0	0					6390	6390 REPLACEM	1,154	
7720		SOCIAL SERVICE SICK & VAC	1589		12	1	0	0					6490	6490 OTHER	1,033	
7730		SOCIAL SERVICE EXPENSES	0	0	12	2	0	0					7280	7280 DRUG PUR	33,207	
7740		OT FEE	33702		39	3	0	-1458 ***					7281	7281 DRUG PUR	34,317	
7750		SOCIAL THERAPIST FEE	0		12	3	0	0					7380	7380 LABORATO	1,493	
7770		SPEECH THERAPY FEE	3890		39	3	0	2935 ***					7391	7390 X-RAY SER	595	
7800		BEAUTICIAN WAGES		0	40	1	0	0					7393	7393 OTHER A S	60	
7810		BEAUTICIAN SICK & VAC			40	1	0	0					7510	7510 ACTIVITIE	27,665	
7820		BEAUTICIAN FEES	0	0	40	3	0	0					7540	7540 ACTIVITIE	999	
7890		BEAUTY SHOP SUPPLIES	0	0	40	2	0	0					7590	7590 ACTIVITIE	942	
7910		VOLUNTEER COORDINATOR	0		21	1	0	0					7595	7595 ACTIVITIE	112	
7940		VOL COORD SICK & VAC	0		21	1	0	0					7610	7610 PHYSICAL	0	
7960		VOL COORD SUPPLIES	0		21	2	0	0					7611	7611 PHYSICAL	0	
8100		RENT	0	0	34	3	0	0					7620	7620 PHYSICAL	52,734	
8120		INTEREST EXPENSE	116438	117789	32	3	14	0					7660	7660 P.T. SUPPL	199	
8130		DEPRECIATION	61181	61181	30	3	9	0					7710	7710 SOCIAL SE	16,986	
8150		LOAN FEE AMORTIZATION	1351		32	3	0	0	40078				7720	7720 SOCIAL SE	1,589	
9510		INTEREST INCOME	-48		32	0	10	-48					7730			
9520		MISC NON-OPERATING INCOME	0		0	0	0	0					7740	7740 OCCUPATI	33,702	
9700		INCOME TAXES	0		0	0	0	0					7750			
			2193399	2193447									7770	7770 SPEECH TH	3,890	
				48									7820	7820 BEAUTICIA	0	
GRAND TOTALS			264177					-73115					7890	7890 BEAUTY SI	0	
			(NET INCOME)										7910			
			0										7940			
		FACILITY NAME:											7960			
		FACILITY ID:	0										8120	8120 INTEREST	86,802	
													8125	8125 ALLOCATE	29,636	
													8130	8130 DEPRECIA	61,181	
		FACILITY UNITS:	89										8150	8150 LOAN FEE	1,351	
													9510	9510 INTEREST	(48)	
		BALANCE SHEET TOTAL	0										9520			
			-264177										9530			
													9700			
																264177